*Welcome to Our Office*

**PATIENT REGISTRATION**
(Please Print)

DATE ______________ HOME PHONE __________ WORK PHONE __________

## PATIENT INFORMATION

NAME ______________________________ SOC SEC # __________

SPOUSE ______________________________

ADDRESS ______________________________

CITY ______________________ STATE __________ ZIP __________

SEX ☐ M ☐ F AGE ______ BIRTHDATE ______________

EMPLOYED BY ______________________ OCCUPATION __________

BUSINESS ADDRESS ______________________________

Whom may we thank for referring you? ______________________________

In case of emergency, who should be notified? ______________________________

## PRIMARY INSURANCE

Person responsible for account? ______________________________

Relation to patient? __________ Birthdate ____________ Soc. Sec. # ____________

Address (If different) ______________________ Phone __________

Person Responsible Employed by ______________________ Occupation __________

Business Address ______________________ Phone __________

INSURANCE COMPANY ______________________________

CONTRACT # __________ GROUP # __________ SUBSCRIBER # __________

## ASSIGNMENT AND RELEASE

I hereby authorize my dentist to release this information as appropriate for insurance collection, referring dental consultations (if needed) and as otherwise may be necessary in maintaining my dental health. I understand I am responsible for all costs of dental treatment.

SIGNATURE ______________________________ DATE ______________